Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS641HOS	A. BUILDING _____ B. WING _____	12/17/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT SPRINGS HOSPITAL	2075 EAST FLAMINGO ROAD LAS VEGAS, NV 89119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments This Statement of Deficiencies was generated as a result of a State Licensure focused survey and complaint investigation conducted in your facility on 12/15/09 and finalized on 12/17/09, in accordance with Nevada Administrative Code, Chapter 449, Hospitals. Complaint #NV00023029 was substantiated with deficiencies cited. Refer to Tag S0310. Complaint #NV00022959 was substantiated with deficiencies cited. Refer to Tag S523 Complaint #NV00023701 was unsubstantiated. Complaint #NV00023842 was unsubstantiated. Complaint #NV00023042 was unsubstantiated. A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included. Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following regulatory deficiencies were identified:	S 000	1/15/10 Accepted as printed	
S 105 SS=E	NAC 449.322 Housekeeping Services 1. A hospital shall establish organized	S 105	The facility reviewed the 7-Step cleaning process with all EVS employees, including but not limited	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Carla McKinnon Performance Improvement Manager 1/15/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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S 310	Continued From page 7 accurate as related to the condition of the patient. This Regulation is not met as evidenced by: Based on interview, policy review, and review of the patient's chart the facility failed to ensure pain assessments were done per hospital policy for one of 19 patients (patient #17). Severity: 2 Scope: 1 Complaint #NV00023029	S 310	were reviewed with all clinical staff via huddles, huddle communication books, and direct conversation with emphasis on pain management assessment and re-evaluation. Responsible persons: Clinical unit Manager/Director and Clinical Nurse Supervisors. Date of Completion: 2/5/10	
S 340 SS=F	NAC 449.363 Personel Policies 5. The hospital shall ensure that the health records of its employees contain documented evidence of surveillance and testing of those employees for tuberculosis in accordance with chapter 441A of NAC. This Regulation is not met as evidenced by: Based on record review, interview and policy review, the facility failed to ensure 5 of 20 employees met the requirements of NAC 441A concerning tuberculosis (TB). (Employees #10, #11, #13, #18 and #19) 1. The files for Employees #10, #11, #13, #18 and #19 did not meet the annual one-step TB skin test requirements, in accordance with NAC 441A.375. Severity: 2 Scope: 3	S 340	The policies and practices for surveillance and testing of employees for tuberculosis were reviewed and revisions are being made to bring the facility into compliance with Chapter 441A of NAC. Responsible Person: Employee Health Nurse Date of Completion: 2/12/10	
S 523 SS=D	NAC 449.379 Medical Records 8. All medical records must document the following information, as appropriate: (e) Properly executed informed consent for all procedures and treatments specified by the	S 523	The patient identified has been discharged prior to the survey and it is not possible to address this particular patient. All patient have the potential to be affected by this practice.	

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S 523	Continued From page 8 medical staff, or federal or state law, as requiring written patient consent. This Regulation is not met as evidenced by: Based on observation, staff interviews, record review and document review, the facility failed to obtain written patient consent for admission and a medical procedure for 1 of 19 patients (Patient #18). Severity: 2 Scope: 1 Complaint #NV00022959	S 523	The policy related to informed consent was reviewed and no revisions were required. Review of the policy was completed by use of twice daily huddles, huddle communication books, and direct conversation at staff meetings. In addition, a FAQ was distributed to all clinical staff which further defined who, when, and how an informed consent is obtained. Admitting staff will also be included in this education process due to need to obtain consent for admission and treatment. Responsible Person: Unit Managers/ Directors, Clinical Nurse Supervisors, Admitting Manager Date of Completion: 2/5/10	